WORKERS COMPENSATION COMMISSION

STATEMENT OF REASONS FOR DECISION OF THE APPEAL PANEL IN RELATION TO A MEDICAL DISPUTE

Matter Number:	**M1-5491/20**
Appellant:	**Rosario Lampasona**
Respondent:	**Musumeci Investment Holdings t/as Fresh Point Fruit Market**
Date of Decision:	**12 February 2021**
Citation No:	**[2021] NSWWCCMA 30**

Appeal Panel:	
Arbitrator:	**Ross Bell**
Approved Medical Specialist:	**Associate Professor Michael Fearnside**
Approved Medical Specialist:	**Dr Michael Davies**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 1 December 2020, Rosario Lampasona (appellant) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr John Hugh O'Neill, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 2 November 2020.

2. The appellant relies on the following grounds of appeal under s 327(3) of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act):

    - Availability of additional relevant information (being evidence that was not available to the appellant before the medical assessment appealed against or that could not reasonably have been obtained by the appellant before the medical assessment);
    - the assessment was made on the basis of incorrect criteria,
    - The medical assessment certificate contains a demonstrable error.

3. The appeal form (Form 10) indicates that a ground of appeal is the deterioration of the worker's condition, but this is taken by the Panel to be in error, because there are no submissions regarding this ground of appeal, and no apparent basis for it.

4. The appeal form also does not indicate that a ground of appeal is that the medical assessment certificate contains a demonstrable error, yet there are brief submissions to this effect. The Panel is satisfied that the intention of the appellant was to rely on this ground.

5. The Registrar is satisfied that, on the face of the application, at least one ground of appeal has been made out. The Appeal Panel has conducted a review of the original medical assessment but limited to the ground(s) of appeal on which the appeal is made.

6. The Workers compensation medical dispute assessment guidelines set out the practice and procedure in relation to the medical appeal process under s 328 of the 1998 Act. An Appeal Panel determines its own procedures in accordance with the Workers compensation medical dispute assessment guidelines.

7. The assessment of permanent impairment is conducted in accordance with the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment, 4th* ed 1 April 2016 (SIRA Guidelines) and the *American Medical Association Guides to the Evaluation of Permanent Impairment,* 5th ed (AMA 5).

RELEVANT FACTUAL BACKGROUND

8. It is convenient to extract the history reported by the AMS at Part 4 of the MAC,

> "Brief history of the incident/onset of symptoms and of subsequent related events, including treatment:
>
> Mr Lampasona told me it had started to rain. He said a pallet had been loaded into the cool room. He said that he climbed a three-metre ladder to get onto the top of the pallet. He said he was reaching down to lift a packet of strawberries which were being passed up to him when he lost balance and fell.
>
> He was taken by ambulance to Prince of Wales Hospital where he remained for six days.
>
> He was subsequently seen on 18 May 2009 by Dr David Sharpe (neurologist). Dr Sharpe noted that in the fall, Mr Lampasona's head hit the ground. There was no loss of consciousness. There was clear recollection of events. Dr Sharpe noted there was "a headache which lasted for the best part of three weeks and at the time of consultation there were still some left rib pains and some pain in the back." Dr Sharpe noted that "from day 1 he was suffering episodic vertigo described as a brief sensation of spinning, sometimes associated with a feeling of nausea and occasionally vomiting".
>
> Dr Sharpe could not confirm the likely diagnosis of a post-traumatic positional vertigo by Hallpike's test. He did note "neck movements were full and pain free".
>
> Dr Sharpe noted that an MRI brain scan at St Vincent's General Hospital on 11 May 2009 had shown no evidence of traumatic intracranial injury.
>
> I rang for the results of a CT scan of the brain, cervical spine and abdomen undertaken at Prince of Wales Hospital on 11 April 2009. That study did report "a left L2 transverse process fracture".
>
> Dr Sharpe referred Mr Lampasona to Dr Shaun Watson (neurologist with special expertise in neuro-otology). At initial consultation on 28 July 2009, Dr Watson stated "I strongly suspect he does have some post-traumatic benign paroxysmal positioning vertigo" although Dr Watson did then find it difficult to confirm this by a Hallpike's test.
>
> By 15 September 2009, audiometry had been performed and was found to be normal. Serc had been tried and had not been helpful. On 15 September 2009, Dr Watson stated "the Hallpike's test was extremely vigorously positive in the head left position with violent upbeat/torsional nystagmus that persisted for about thirty seconds".
>
> Dr Watson arranged balance physiotherapy with Mr Ross Black.

> The vertigo proved to be a persistently intrusive problem for Mr Lampasona. By 7 August 2014, Dr Watson was able to stop regular visits but even then, Mr Lampasona was "still getting slight dizziness and still had to be careful with quick head movements but was enjoying his work as a traffic controller".
>
> Dr Watson had to resume consultations on 10 August 2017 because "on 13 April 2017 he experienced severe vertigo and vomiting that commenced at 4am and persisted until 4pm. He ended up in Prince of Wales Hospital" for six days. A CT/CTA brain scan and MRI were negative for stroke.
>
> On 9 November 2017, Dr Watson noted "we have previously tried the Omniax at Royal Prince Alfred Hospital but it made him terribly sick".
>
> On 8 March 2018, Dr Watson said 'I looked after him in Prince of Wales Hospital from 5 to 6 December when he presented with particularly severe vertigo'."

PRELIMINARY REVIEW

9. The Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the WorkCover Medical Assessment Guidelines.

10. As a result of that preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination for the reasons given below.

EVIDENCE

Fresh evidence

11. Section 328(3) of the 1998 Act provides that evidence that is fresh evidence or evidence in addition to or in substitution for the evidence received in relation to a medical assessment appealed against may not be given on an appeal by a party unless the evidence was not available to the party before the medical assessment and could not reasonably have been obtained by the party before that medical assessment.

12. The appellant seeks to admit the following evidence:

    (a) Dr Paul Darveniza, Neurologist, report dated 17 November 2020.

13. The appellant submits that the further report of Dr Darveniza is relevant as a rebuttal of the AMS's assertion that Dr Darveniza used the incorrect Table to assess vestibular impairment.

14. The respondent submits that the additional report of Dr Darveniza is not fresh evidence within the meaning of s 328(3) of the 1998 Act. The AMS had Dr Darveniza's report of 23 August 2018 provided to him and the recent report does not provide additional relevant information. The recent report has no probative value and is only a commentary on the findings of the AMS. The report should not be admitted.

15. Section 328(3) of the 1998 Act sets out the conditions for the admission of new evidence on appeal:

> "(3) Evidence that is fresh evidence or evidence in addition to or in substitution for the evidence received in relation to the medical assessment appealed against may not be given on an appeal by a party to the appeal unless the evidence was not available to the party before that medical assessment and could not reasonably have been obtained by the party before that medical assessment."

16. In *Lukasevic v Coates Hire Operations Pty Limited* [2011] NSWCA 112 (*Lukasevic*). Hodgson JA, in the majority, says (at 78),

> "A dispute by the worker as to the history set out in the certificate, or the observations made by the AMS, can readily be raised; and it could be raised honestly or dishonestly, on strong or flimsy grounds. Having regard to the matters I have set out, in my opinion it would be reasonable for an AP [Appeal Panel] not to admit evidence raising such a dispute unless that evidence had substantial prima facie probative value, in terms of its particularity, plausibility and/or independent support. Otherwise, simply by raising such a dispute, going to a matter relevant to the correctness of the certificate, a worker could put the AP in a position where it had to have a further medical examination conducted by one of its members. I do not think this would be in accord with the policy of the WIM Act."

17. In *Petrovic v BC Serv No 14 Pty Limited and Ors* [2007] NSWSC 1156 (*Petrovic*) Hoeben J said,

> "In my opinion the words "availability of additional relevant information" qualify the words in parentheses in s327(3)(b) in a significant way. The information must be relevant to the task which was being performed by the AMS. That approach is supported by subs 327(2) which identifies the matters which are appealable. They are restricted to the matters referred to in s326 as to which a MAC is conclusively taken to be correct. In other words, "additional relevant information" for the purposes of s327(3)(b) is information of a medical kind or which is directly related to the decision required to be made by the AMS. It does not include matters going to the process whereby the AMS makes his or her assessment. Such matters may be picked up, depending on the circumstances, by s327(3)(c) and (d) but they do not come within subs 327(3)(b)."

18. The report of Dr Darveniza of 17 November 2020 generally confirms the earlier history taken and his opinion before going on to express views on the findings of the AMS. The report is in the same category as that at issue in *Lukacevic*.

19. The application for the report to be admitted also does not satisfy s 328(3) of the 1998 Act because Dr Darveniza states that his opinion in the report of 23 August 2018 remains unchanged.

20. The issue of the correct Table for the assessment is a matter for the Panel and the opinion of a practitioner about issues of the correct criteria or issues of possible error is a matter for the Panel without the need for commentary from other assessors after the issuing of the MAC. The Panel notes that Dr Darveniza's speculation as to the whether an ear nose and throat specialist (ENT) must assess dysequilibrium is of no assistance. The report does not have "substantial *prima facie* probative value, in terms of its particularity, plausibility and/or independent support." (*Lukacevic*).

21. For these reasons, the Appeal Panel determines that the supplementary report of Dr Darveniza should not be received on the appeal because it does not satisfy section 328(3) of the 1998 Act or the relevant authorities.

22. The Panel notes that a report of Dr Renata Bazina, Neurosurgeon/ Pain Specialist, dated 28 May 2018, was filed via the Commission's electronic portal by one of the parties on 21 January 2021, after the matter had been referred by the "gatekeeper" to the Panel pursuant to s 327 of the 1998 Act. This document appears to have been lodged by the respondent, but there is no other documentation with the report, and there are no submissions as to why the document has been lodged, or why it should be admitted by the Panel. If such were the intention, the document is far too late. It came into existence in May 2018 and yet was not part of the material before the AMS or annexed to the Appeal or Response. The document also has no apparent probative value for the appeal. The document is excluded.

Documentary evidence

23. The Appeal Panel has before it all the documents that were sent to the AMS for the original medical assessment and has taken them into account in making this determination.

Medical Assessment Certificate

24. The parts of the medical certificate given by the AMS are set out, where relevant, in the body of this decision.

SUBMISSIONS

25. The appeal relates only to the assessment for vestibular impairment. The assessment of the cervical spine is not appealed.

26. Both parties made written submissions. They are not repeated in full but have been considered by the Appeal Panel. In summary the parties submit:

Appellant

27. The AMS has erred in asserting that vestibular impairment cannot be assessed by a neurologist such as himself and has also thereby applied incorrect criteria.

28. The AMS has also erred in the assertion that Dr Darveniza, neurologist, used the wrong AMA 5 Table in his assessment yet did not nominate the correct Table.

Respondent

29. The AMS did not err or apply incorrect criteria in making the assessment. The means for assessment of vestibular impairment are in Chapter 11 of the SIRA Guidelines.

30. The AMS was entitled to agree with and adopt the assessment of Dr Williams from his MAC of February 2013.

31. The MAC should be confirmed.

FINDINGS AND REASONS

32. The procedures on appeal are contained in s 328 of the 1998 Act. The appeal is to be by way of review of the original medical assessment, but the review is limited to the grounds of appeal on which the appeal is made.

33. In *Campbelltown City Council v Vegan* [2006] NSWCA 284 the Court of Appeal held that the Appeal Panel is obliged to give reasons. Where there are disputes of fact it may be necessary to refer to evidence or other material on which findings are based, but the extent to which this is necessary will vary from case to case. Where more than one conclusion is open, it will be necessary to explain why one conclusion is preferred. On the other hand, the reasons need not be extensive or provide a detailed explanation of the criteria applied by the medical professionals in reaching a professional judgement.

Ground of appeal – assessment of vestibular impairment

34. The AMS explained at Part 10.a,

> "As agreed by Drs Sharpe, Watson, Darveniza (report of 23 August 2018) and Mellick (reports of 23 Dec 2009 and 13 Jan 2020), I have no doubt that the fall on 11 April 2009 gave rise to post-traumatic positional vertigo which has most unusually been persistent and has certainly been intrusive in Mr Lampasona's life.

> The NSW Workers' Compensation Guidelines 2016 dictate that dysequilibrium should be assessed by an ENT specialist. Mr Lampasona was seen by Dr Brian Williams (ENT specialist) for the WCC on 20 February 2013 and Dr Williams found there was 5% whole person impairment as a consequence of dysequilibrium arising from post-traumatic positional vertigo.
>
> Whilst I sympathise with the view of Dr Darveniza (report of 23 August 2018) who suggested there was 29% WPI for vestibular impairment given the extent to which symptoms affected Mr Lampasona's life, I do not see that I can recommend greater impairment than that assessed by Dr Williams in 2013. I note Dr Darveniza used the incorrect Table when arriving at his assessment of impairment.
>
> In short therefore, I have agreed with Dr Williams that there is 5% whole person impairment due to post-traumatic positional vertigo."

35. The above extract comprises the core subject matter of the appeal.

36. Chapter 6 of the SIRA Guidelines sets out the process for assessment of the "Ear, nose, throat and related structures". The Introduction comprises,

> "6.1 AMA5 Chapter 11 (pp 245–75) details the assessment of the ear, nose, throat and related structures. With the exception of hearing impairment, which is dealt with in Chapter 9 of the Guidelines, AMA5 Chapter 11 should be followed in assessing permanent impairment, with the variations included below.
>
> 6.2 The level of impairment arising from conditions that are not work-related needs to be assessed by the medical assessor and taken into consideration in determining the level of permanent impairment. The level at which pre-existing conditions and lifestyle activities, such as smoking, contribute to the level of permanent impairment requires judgement on the part of the clinician undertaking the impairment assessment. The manner in which any deduction for these is applied needs to be recorded in the assessing specialist's report."

37. Paragraph 6.3 specifies the method for assessing equilibrium impairment,

> "Equilibrium is assessed according to AMA5 Section 11.2b (pp 252–55), but add these words to AMA5 Table 11-4, class 2 (p 253): 'without limiting the generality of the above, a positive Hallpikes test is a sign and an objective finding'."

38. The Panel observes that, contrary to the comment of the AMS, there is no requirement in Chapter 6 for such assessments to be carried out by an ENT specialist. This misapprehension has led the AMS into two errors: he has not proceeded to discharge the obligation to assess the dysequilibrium referred to him; and he has simply adopted an assessment by Dr Brian Williams from his MAC issued on 20 February 2013.

39. It is possible that the AMS was referring to Chapter 9 of the SIRA Guidelines concerning Hearing which provides at paragraph 9.1 that "… the medical assessment should be undertaken by an ear, nose and throat specialist or other appropriately qualified medical specialist." This is however not a requirement for vestibular disorders, addressed in Chapter 6.

40. Regarding the appellant's submissions as to the assessment of Dr Darveniza, the Panel notes that Dr Darveniza has assessed the disorder using Table 13-13 at page 312 of AMA 5 rather than Table 11-4 at page 253, contrary to paragraph 6.3 of the SIRA Guidelines.

41. The failure by the AMS to assess the vestibular disorder, but rather to adopt an old assessment from a previous MAC from February 2013 based on a misapprehension is a demonstrable error on the face of the Certificate. The lack of any requirement for the vestibular disorder to be assessed by an ENT; and the adoption of the assessment of Dr Williams from 2013 also means that the assessment was based on incorrect criteria.

Findings

42. If a ground of appeal is successfully made out and an error identified, the Panel must correct the error or errors found "applying the WorkCover Guides fully" (see *Roads and Maritime Services v Rodger Wilson* [2016] NSWSC 1499).[1] The Panel is able to make the assessment and correct the errors found above without recourse to further examination of Mr Lampasona.

43. The symptoms or signs of vestibular dysequilibrium set out in Table 11-4 of AMA 5 for all Classes (as modified by paragraph 6.3 of the SIRA Guidelines) have been confirmed by multiple treating and assessing specialists, including Hallpike's test, and the Panel finds the criteria met.

44. The injury is permanent and has reached maximum medical improvement.

45. There is an emphasis for the purposes of assessment on the activities of daily living (ADLs) in Table 11-4. The history taken by the AMS and the other assessors is sufficient for the Panel to assess the impairment using the Table.

46. The AMS took the following history under "Present symptoms", consistent with Mr Lampasona's statement,

> "Mr Lampasona told me he experiences dizziness on a daily basis. It is such that he can never lie flat in bed and has to sleep in a special bed with the head inclined. He cannot run, swim or engage in hobbies such as fishing. "It has totally changed my life".
>
> He said he is prone to worse episodes "with a change in weather". He said initially he would feel a headache across the front of the head followed by nausea and then there would be dizziness with spinning of the environment and nausea and vomiting. He has had to go to hospital with such symptom approximately every six months. A bad attack could last up to a week.
>
> For a bad attack he would take a combination of Panadol and Aspirin for the headache; Stemetil to try to settle the vertigo and an Ondansetron wafer when necessary for nausea with vomiting."

47. Dr Watson, treating neurologist, also recorded the symptoms through his series of treating reports.

48. Dr Darveniza in his report of 23 August 2018 noted a history consistent with that taken by the AMS,

> "During the day. provided he remains upright. he avoids vertigo but he can't engage in any activities which require lifting. bending and stooping and other activities where vertigo would he a danger to himself or others, such as climbing ladders, riding bicycles, driving, vacuuming or hanging washing.
> …
> He lives with a nephew who does heavier household chores and other chores requiring stooping and looking up. He lives in an apartment. Since the accident he has given up fishing, water sports including swimming, cycling and riding. Recreation and socialisation have also been restricted because of his recurrent attacks of vertigo and he is unable to drive a vehicle."

[1] See also *NSW Police Force v Registrar of the Workers Compensation Commission of NSW* [2013] NSWSC 1792.

49. The Panel is of the view that the effect on ADLs of the dysequilibrium places Mr Lampasona in Class 3 of Table 11-4, toward the lower end of that Class. The Panel finds the severity of the symptoms places him at 15% WPI for vestibular impairment within Class 3.

50. There is no deduction applicable pursuant to s 323 of the 1998 Act or for any other reason, giving a final WPI of 15%, as reflected in the Panel's Certificate below.

51. For these reasons, the Appeal Panel has determined that the MAC issued on 2 November 2020 should be revoked, and a new MAC issued. The new Certificate is attached to this statement of reasons.

I CERTIFY THAT THIS IS A TRUE AND ACCURATE RECORD OF THE REASONS FOR DECISION OF THE APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

A Shaw

Andrew Shaw
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Matter Number: **5491/20**
Appellant: **Rosario Lampasona**
Respondent: **Musumeci Investment Holdings t/as Fresh Point Fruit Market**

This Certificate is issued pursuant to s 328(5) of the *Workplace Injury Management and Workers Compensation Act 1998*.

The Appeal Panel revokes the Medical Assessment Certificate of Dr John Hugh O'Neill and issues this new Medical Assessment Certificate as to the matters set out in the Table below:

Table - Whole Person Impairment (WPI)

Body Part or system	**Date of Injury**	**Chapter, page and paragraph number in NSW Workers Compensation Guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA5 Guides**	**% WPI**	**WPI deductions pursuant to s 323 for pre-existing injury, condition or abnormality** (expressed as a fraction)	**Sub-total/s % WPI** (after any deductions in column 6)
Cervical spine	11 April 2009	Para 4.24 page 26	Table 15-5 p.392	0	n/a	0
Vestibular impairment	11 April 2009	Chapter 6 Page 34 Para 6.3	Chapter 11 pp 252-255 Table 11-4	15	nil	15
Total % WPI (the Combined Table values of all sub-totals)					**15**	

Ross Bell
Arbitrator

Associate Professor Michael Fearnside
Approved Medical Specialist

Dr Michael Davies
Approved Medical Specialist

12 FEBRUARY 2021

I CERTIFY THAT THIS IS A TRUE AND ACCURATE RECORD OF THE MEDICAL ASSESSMENT CERTIFICATE OF THE APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

A Shaw

Andrew Shaw
Dispute Services Officer
As delegate of the Registrar